STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G319 09/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 211 W 3RD STREET REM-INDIANA INC PERU. IN46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE W0000 All Mentor employees are trained W0000 on client rights as well as This visit was for the investigation of reporting of abuse, neglect and complaint #IN00096220. exploitation. Staff in home will be retrained on both client rights and the policy of reporting of abuse, Complaint #IN00096220: neglect and exploitation. Client A SUBSTANTIATED, Federal and State who requires 1:1 staffing will have deficiencies related to the allegation were assigned staff to work directly cited at W149, W156, and W227. with her. The assigned staff will be indicated on the house schedule. Upon an assigned staff Dates of Survey: September 19, 20, and calling off for their scheduled shift 21, 2011. the staff another staff will be assigned as client A's 1:1 staff Provider Number: 15G319 person. This will not automatically be the staff person Facility Number: 000837 replacing the staff who called off AIM Number: 100243970 but will be assigned by the **Program Director or House** Surveyor: Susan Eakright, Medical Manager. All program staff will also be retrained on approved Surveyor III/QMRP PIA Techniques(Physical Intervention Strategies) which These deficiencies also reflect state should be used only according to findings in accordance with 460 IAC 9. clients approved plan of care. Staff will also be retrained that Quality Review completed 9/30/11 by any use of PIA should be reported Ruth Shackelford, Medical Surveyor III. to the House Manager, Program Director or on-call Supervisor if during on call hours. Staff and Supervisors will be retrained on BDDS reportable incidents and timeline for reporting. Staff will be retrained on client supervision levels required for each client. This will include retraining that sleeping on the job or failure to provide adequate supervision levels will result in termination.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000837

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 10/20/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		00	(X3) DATE S COMPL	ETED
		15G319	B. WIN			09/21/20	011
	PROVIDER OR SUPPLIER		•	211 W 3	DDRESS, CITY, STATE, ZIP CODE BRD STREET IN46970		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W0149	written policies and mistreatment, negative section of the section	gations of staff neglect acility neglected to of the investigation sys to the administrator, areau of Developmental es) according to state	W	0149	Staff will be retrained on actitreatment guidelines and requirements. Indiana Mento investigate any allegations or abuse, neglect, or exploitation immediately and develop recommendations within 5 da These recommendations will implemented immediately by Program Director and will be reported to the team and APBDDS follow up will be composition within 7 days of the initial BD report and will include the recommendations and verify they have been implemented well as any additional measure to be taken. All Mentor employees are trained on both client rights the policy of reporting of abuse, neglect a exploitation. Staff in home were trained on both client rights the policy of reporting of abuse neglect and exploitation. Client who requires 1:1 staffing will assigned staff to work directle with her. The assigned staff be indicated on the house scheduled shift the staff and staff will be assigned as clien 1:1 staff person. This will no automatically be the staff per replacing the staff who called but will be assigned by the Program Diror House Manager. Upon ar assigned the staff who called but will be assigned by the Program Diror House Manager. Upon ar assigned the staff who called but will be assigned by the Program Diror Program Diror House Manager. Upon ar assigned the staff who called but will be assigned by the Program Diror Program Diror Program Director or House	or will f on ays. be the S. A oleted DDS that d as ares ained ind will be a and se, ent A have y will rector their ther at A's at reson	10/19/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BRN411

Facility ID:

000837

If continuation sheet

Page 2 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	00			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	15G319	A. BUI	LDING		09/21/2	
		136319	B. WIN			09/21/2	011
NAME OF	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
REM-INI	DIANA INC			1	BRD STREET IN46970		
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
		•			Manager. All program staff w	/ill	
	1 On 0/10/11 or	t 3:15pm, the facility's			also be retrained by the Prog		
					Director on approved PIA		
		opmental Disability			Techniques(Physical Interve		
	1	s from 8/1/11 through			Strategies) which should be		
	9/19/11 were rev	viewed and indicated the			only according to clients app		
	following:				plan of care. Staff will also be retrained by the Program Dir		
					that any use of PIA should be		
	-A BDDS Repor	t on 9/1/11, for an			reported to the House Manag		
	_	/11 at 8pm, indicated			Program Director or on-call		
		n one staff was suspended			Supervisor if during on call		
		-			hours.Retrained on BDDS	_	
pending an allegation of alleged verbal and physical abuse by (Direct Care Staff				reportable incidents and time	eline		
	1 1	• `			for reporting for staff will be provided by the Program Dire	ootor	
	1 ' ' '	e report indicated "the			as well as the House Manag		
	_	that the suspended staff			and Program Director receiving		
] into the toilet in [client			retraining by the Area	5	
	A's] bathroom a	nd cursed at [client A]."			Director.Staff will be retraine	d on	
	The report indicate	ated client A had no			client supervision levels requ		
	visible injuries a	nd DCS #1 was			for each client by the Program	m	
	suspended pendi	ng an investigation. No			Director. This will include retraining as to sleeping on t	ho	
	follow up report	was available for review.			job or failure to provide adeq		
					supervision levels will result		
	On 9/21/11 at 9:	45am the 9/5/11			termination. Staff will be retra		
		o the incident on 8/31/11			on active treatment guideline		
		id indicated the following:			and requirements. Indiana M		
		•			Program Director or Area Dir		
		client A screaming and			will investigate any allegation abuse, neglect, or exploitation		
		OCS #4 went to client A's			immediately and develop		
		CS #4 saw DCS #1 "push			recommendations within 5 da	ays.	
		t the wall in [client A's]			These recommendations will	be	
		ıl (sic) with both hands."			implemented immediately by		
	The investigation	n indicated DCS #4 heard			Program Director and will be		
	DCS #1 state to	client A "I am not dealing			reported to the team and APS BDDS follow up will be comp		
	with this s ton	ight." The 9/5/11			within 7 days of the initial BD		
	investigation ind	licated DCS #4 saw client			report by the Program Direct		
	A crying, scream	ning, and was "upset."			and will include the		

000837

l '		(X2) MULT	ΓIPLE CON	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G319	A. BUILDI	NG	00	09/21/2	
		130319	B. WING			09/21/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE RD STREET		
REM-INF	DIANA INC		I .	PERU, I			
		TATEL OF DEFICIENCIES					QUE)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		ΓAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
		,		İ	recommendations and verify	that	
	DCS #5 stated h	e was to have been client			they have been implemented		
		taff on 8/31/11 "but [DCS			well as any additional measu	res	
		e on one responsibilities"			to be taken.		
		o DCS #5 supervised					
	1	e investigation indicated					
		nt A's one on one staff					
		ng" for an outing. DCS					
		were no behavioral issues					
		ntil [DCS #1] tried to get					
	1 - 1	and [client A] was not					
	1	estigation indicated DCS					
	1 *	#1 in client A's bedroom					
		d screaming and yelling.					
	DCS #4 went to						
		and requested DCS #5					
		ecause [DCS #1] just					
	1	and [DCS #1] told					
		re [client A's] bedroom"					
		could hear client A					
		#5 stated he went to					
	client A's bedroo						
		ne saw [client A's] depend					
	·	ontinent brief) thrown all					
	`	eces of it shredded					
	· · ·	[client A] sitting on the					
	1	n and shaking." The					
		icated DCS #5 stated					
	_	pset and [DCS #5] asked					
	1	ld like to step outside he					
		[DCS #1] stated no, she					
		under control." The					
		icated DCS #5 "told"					
	1	e needed to step outside					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G319			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/21/2011	
	PROVIDER OR SUPPLIER		2	11 W 3	DDRESS, CITY, STATE, ZIP CODE RD STREET N46970		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	client A. DCS #: not leave." DCS stated to him "the me." DCS #5 sta the bathroom ask area that client A the toilet and he reason, [DCS #1' on the toilet, with A's] left shoulder -DCS #1's statem client A came up client A hit DCS she "stopped [cli approved PIA (P) Alternatives) tech she tried to get ch because client A indicated client A "at this time I gra The report indicate both client A's w indicated client A "soaked" clothin #1 stated "she ha sides because [cl [DCS #1] assist. from the sides to that is when she	nd he would finish with 5 stated DCS #1 "would #5 stated that DCS #1 e f b just slapped ated that while he was in sing DCS #1 to leave the went to stand up from saw DCS #1 "for no pushed [client A] down two hands on [client forceful push (sic)." The ent indicated at 7:45pm stairs to her bedroom and #1. DCS #1 indicated ent A] hand with an hysical Intervention hinque. DCS #1 stated lient A to the bathroom was wet. DCS #1 at ried to scratch DCS #1, abbed ahold of her wrist." In the dCS #1 grabbed rists. The investigation is would not get out of her g and adult brief. DCS d to rip the brief off the ient A] would not let When I ripped the briefs get them off [client A] threw the brief at me and many directions and a nother bathroom."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G319		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING 00 COMPLE 09/21/20		ETED			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		1	BRD STREET		
	DIANA INC			PERU,	IN46970		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG		of the investigation	+	IAG	,		DATE
	1	A had established one on					
		place and DCS #1					
	1 -	otocol when [DCS #1] left					
	_	stairs in the dining room					
	1 "	ft the house during her					
	1 -	mission, and also used					
	1	ive moves on [client A],					
		dmitted are not approved					
	1 - 1	PIA techniques." No					
	1	estigation were available					
	for review.	Č					
	On 9/21/11 at 9:	45am, the results of client					
	A's investigation	n indicated DCS #1 was					
	terminated from	employment on 9/21/11.					
	1	45am, an interview with					
	1	ector and the Regional					
	` ′	ras completed. Both					
	1	ults of the facility					
	1 -	client A's 8/31/11					
	1 ~	ot been reported to BDDS					
	in accordance w	ith state law.					
		d was reviewed on 9/19/11					
	1 ^	nt A's 12/21/10 ISP					
	1 .	port Plan) and a 5/2011					
	`	ce Guide" for client A's					
	1	behavior development					
	` ′	icated her behaviors					
		re not limited to physical					
	1	A's "Physical Assault" was					
	defined as "atter	npts or actual attacks					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G319		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey Pleted /2011	
	PROVIDER OR SUPPLIER		211 W 3	ADDRESS, CITY, STATE, ZII BRD STREET IN46970	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	directed at one of the apparent interinjury, and taking of the following: pinching, kicking head butting, pus a held or propelled plan indicated shouse of client toward staff supervision because of client toward staff and 2. On 9/19/11 at BDDS (Bureau or Disability Service through 9/19/11 indicated the following (clients B, member being throuse (clients B, member being throuse (clients B, member being throuse indicated DCS #2] has one with another made the accusate indicated DCS #3 indicated the procalled, the PD called, the PD called in the procalled i	r more individuals with nt to produce pain or g the form of one or more hitting, scratching, g, biting, pulling hair, shing, and/or striking with ed object." Client A's e "required" one on one during "all" awake hours A's physical aggression other clients. 3:15pm, the facility's of Developmental es) Reports from 8/1/11 were reviewed and owing: ton 8/30/11, for an 11 at 11:30am, indicated OCS #3) was suspended of allegedly sleeping on e three clients in the C, and F) with this staff e sole staff in the house fon occurred. The second ad arrived from a one on client (client A) and fion." The report 2 stated "[DCS #3] was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G319		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 09/21/2	ETED	
		100010	B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/21/2	011
NAME OF	PROVIDER OR SUPPLIE	₹			BRD STREET		
REM-INI	DIANA INC			1	IN46970		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
	report was availa	able for review.					
	8/30/11 investigation incident for client reviewed. The investigation incident from DCS # "asleep on the content of the conten	45am, the facility's ation for the 8/28/11 hts B, C, and F was investigation indicated on se Manager received a 2 that DCS #3 was buch when [DCS #2] elient outing with [client indicated DCS #2 was an hour" and clients B, C, are group home. The licated DCS #3 "stated he couch and closed his stated that he had his eyes ten minutes and [DCS The report indicated DCS is not asleep (and) he did clients were." The report 3 "admitted that he did clients were safe mot asleep." The report indicated that when the group home client A cred through the back for alarm was on lighter a stated "the house was there everyone was, and the sofawith his					
	l -	S #2 stated client A left the					
	group nome and	he followed her, he left					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G319	A. BUILDING	00	COMPLETED 09/21/2011
		100019	B. WING		09/21/2011
NAME OF I	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE	
RFM-INF	DIANA INC		l l	3RD STREET IN46970	
(X4) ID		TATEMENT OF DEFICIENCIES	ID ID	1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	, i	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	the back door op	en so he could see inside			
	"since he though	t [DCS #3] was asleep."			
	DCS #2 called the PD at 11:45am.				
	The conclusion to	o the investigation			
	indicated DCS #3	3's "testimony states he			
	"	or approximately fifteen			
		iggests he did not			
	provide appropri	ate supervision."			
		15am, the results of the			
	"	icated DCS #3 was			
	terminated from	employment on 9/21/11.			
	On 0/21/11 at 0:/	45am, an interview with			
		ector and the Regional			
		as completed. Both			
	` ′	alts of the facility's			
		ation for DCS #3 sleeping			
	_	peen reported to BDDS in			
	accordance with	*			
	On 9/19/11 at 2:2	25pm, a record review of			
	the facility's 7/20	006 "Quality and Risk			
	Management" in	dicated the company			
	prohibited abuse,	, neglect, and			
	mistreatment of o	clients, and indicated,			
	_	the failure to by any staff			
	1 **	ly or to ensure the supply			
	l -	d, clothing, shelter, health			
		on for an individual			
	"	he policy/procedure			
	indicated the con	1			
	prohibited includ	le the followingpainful			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPI		
		15G319	B. WING		09/21/2	011
NAME OF I	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	E	
REM-IND	DIANA INC			3RD STREET IN46970		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	BROWNERS IN AN OF CORRES	COTTON	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORREG (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		dy" which included				
		, and the infliction of				
		The provider providing				
	case managemen					
		submit a follow up report				
	_	ncident on the BDDS's				
	•	nt report form at the				
	•	(a) within seven (7) days				
		tial report; (b) every				
	` ' '	ereafter until the incident				
	is resolvedC. In					
		npleting a thorough				
		any event out of the				
	ordinary which jo	eopardizes the health and				
	safety of any ind	ividual served or other				
	employees. 1. In	vestigations will be				
		e following incidents:				
	allegations of sus	spected abuse, neglect, or				
	exploitation2.	Investigation findings				
	will be submitted	d to the Director of				
	Program Service	s for review and				
	development of f	further recommendations				
	as needed within	5 days of the incident."				
	_	relates to complaint				
	#IN00096220.					
	9-3-2(a)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15G319	B. WIN			09/21/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				3RD STREET		
REM_INIT	DIANA INC				IN46970		
TXEIVI-IIVE				I LINO,			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0156	V0156 The results of all investigations must be reported to the administrator or designated						
	representative or to						
		tate law within five working					
	days of the incider						
			1 137	0156	Staff will be retrained on active	ve	10/19/2011
	Based on record review	v and interview, for 8 of 8 clients	"	0130	treatment guidelines and		10/19/2011
		F, G, and H) living in the group			requirements by the Program	1	
	home, the facility faile	d to report within five (5)			Director. Indiana Mentor will		
		ts of the investigations for 2 of 2			investigate any allegations of	f	
		ns of staff neglect and abuse to			abuse, neglect, or exploitatio		
		DDS (Bureau of Developmental			immediately and develop		
	(APS) in accordance w	nd to Adult Protective Services			recommendations within 5 da	ays.	
	(AFS) ili accordance w	Till State law.			These recommendations will	be	
	Findings include:				implemented immediately by	the	
	8-				Program Director and will be		
	1. On 9/19/11 at 3:15p	om, the facility's BDDS (Bureau			reported to the team and APS	S. A	
	of Developmental Disa	ability Services) Reports from			BDDS follow up will be comp	leted	
		were reviewed and indicated the			within 7 days of the initial BD	DS	
	following:				report by the Program Direct	or	
	-	/1/11, for an incident on 8/31/11			and will include the		
		t A's "one on one staff was allegation of alleged verbal and			recommendations and verify		
		ect Care Staff (DCS) #1)." The			they have been implemented		
	report indicated "the al				well as any additional measu		
		[client A] into the toilet in			to be taken.Client A who requ		
	[client A's] bathroom a	and cursed at [client A]." The			1:1 staffing will have assigne		
		A had no visible injuries and			staff to work directly with her	•	
		d pending an investigation. No			The assigned staff will be	dula	
	follow up report was a	vailable for review.			indicated on the house sched		
	On 9/21/11 at 0:45am	the 9/5/11 investigation into the			by the Program Director or H		
		s reviewed and indicated the			Manager. Upon an assigned calling off for their scheduled		
	following:	s reviewed and indicated the			the staff another staff will be	SHILL	
	•	A screaming and heard a noise.			assigned as client A's 1:1 sta	off	
		A's bedroom and DCS #4 saw			person. This will not	***	
		A] against the wall in [client A's]			automatically be the staff per	son	
		with both hands." The			replacing the staff who called		
		DCS #4 heard DCS #1 state to			but will be assigned by the		
		ing with this s tonight." The			Program Director or House		
	9/5/11 investigation inc	dicated DCS #4 saw client A			Manager. All program staff w	rill	
	crying, screaming, and	was upset.			also be retrained by the Prog		
	The conclusion of the i	investigation indicated client A			Director on approved PIA	,. 	

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STATEMEN	OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		I DDIG	00	COMPL	ETED	
		15G319	A. BUII			09/21/2	011	
			B. WIN					
NAME OF P	ROVIDER OR SUPPLIER	t		1	ADDRESS, CITY, STATE, ZIP CODE			
				1	BRD STREET			
	DIANA INC				IN46970			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		n one protocol in place at the time			Techniques(Physical Interver			
		CS #1 "violated the protocol when			Strategies) which should be			
		A] downstairs in the dining room			only according to clients app			
		house during her shift without used forceful aggressive moves on			plan of care. Staff will also b			
	-	#1] admitted are not approved			retrained that any use of PIA			
		hysical intervention alternative)			should be reported to the Ho			
		clusion to the investigation was			Manager, Program Director o			
	the findings of the inv	estigator and not the final report			on-call Supervisor if during o			
	for the incident. No re	esults of the investigation were			hours.Staff and Supervisors			
	available for review.				be retrained on BDDS report	able		
	0.0/01/11 + 0.45	d Cran			incidents and timeline for			
		the results of client A's			reporting. Staff will be retrain			
	employment on 9/21/1	d DCS #1 was terminated from			by the Program Director and Program Director and House			
	employment on 3/21/1	.1.			Manager will be retrained by			
	On 9/21/11 at 9:45am,	, an interview with the Program			Area Director. Staff will be	uie		
		onal Director (RD) was			retrained by the Program Dir	ector		
	completed. Both indic	cated the results of the facility			on client supervision levels	COLOI		
		t A's 8/31/11 allegation had not			required for each client. This	: will		
	-	ty's administrator, to BDDS, or			include retraining that sleeping			
	APS, or in accordance	with state law.			the job or failure to provide	.5		
	2 On 0/10/11 at 2:15	pm, the facility's BDDS (Bureau			adequate supervision levels	will		
		ability Services) Reports from			result in termination.			
	-	I were reviewed and indicated the						
	following:							
	-A BDDS Report on 8	/30/11, for an incident on 8/28/11						
		"staff member (DCS #3) was						
		ation of allegedly sleeping on						
		e clients in the house (clients B,						
		ff member being the sole staff in						
		legation occurred. The second rived from a one on one with						
		A) and made the accusation." The						
	*	#2 stated "[DCS #3] was asleep						
		port indicated the program						
	director (PD) was call	ed, the PD came to the group						
		as suspended from duty" pending						
	an investigation.							
	On 9/21/11 at 9:45am,	, the facility's 8/30/11						
		/28/11 incident for clients B, C,						
		The investigation indicated on						
	8/28/11 the House Ma	nager received a call from DCS						
			1					

000837

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE ((X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G319	A. BUILDING	00	COMPLETED 09/21/2011
		130313	B. WING	CADDRESS CITY STATE ZID CODE	03/21/2011
NAME OF F	PROVIDER OR SUPPLIER		1	ADDRESS, CITY, STATE, ZIP CODE 3RD STREET	
REM-IND	DIANA INC		l l	, IN46970	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		asleep on the couch when [DCS ient outing with [client A]." The			
		#2 was "gone for about an hour"			
		were in the group home. The			
	-	DCS #3 "stated he laid down on			
		nis eyes. [DCS #3] stated that he r about ten minutes and the [DCS			
	·	eport indicated DCS #3 stated "he			
	was not asleep (and) h	e did know where all clients			
		icated DCS #3 "admitted that he			
		ye treatment but did state that he safe and that he was not asleep."			
		-			
		investigation indicated DCS #3's			
		osed his eyes for approximately suggests he did not provide			
		n." The conclusion to the			
	-	findings of the investigator and			
	not the final report for	the incident.			
	On 9/21/11 at 9:45am,	the results of the investigation			
		terminated from employment on			
	9/21/11.				
	On 9/21/11 at 9:45am.	an interview with the Program			
		onal Director (RD) was			
	•	cated the results of the facility			
		for DCS #3 sleeping on duty had ne administrator, to BDDS, to			
	APS in accordance wi				
	This federal tag relates	s to complaint #IN00096220.			
	9-3-2(a)				
W0227	The individual pro	gram plan states the			
., 0227		necessary to meet the			
	client's needs, as				
		ssessment required by			
	paragraph (c)(3) o	TITIS SECTION.	W/0227	Program Director will develo	n a 10/10/2011
	D 1 1		W0227	Program Director will develotoileting goal for client in adu	
		ation, record review, and		incontinence briefs to be	···
	interview for 1 o	f 1 sampled client (client		implemented ongoing for the	,
			1		l l

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE ((X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
15G319		B. WING		09/21/2011		
NAME OF I	PROVIDER OR SUPPLIER			CADDRESS, CITY, STATE, ZIP CODE		
DEM INIT	NANA INC		l l	3RD STREET , IN46970		
REM-INDIANA INC				, IIV + 0970		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	A) who was incontinent and wore adult			duration of incontinence. If	a	
	briefs, the facility failed to initiate programming in client A's Individual			client is incontinent this will		
				noted in the clients ISP and		
	Support Plan (ISP) to address client A's			Behavior Management Plar upon the need for adult	and	
	toileting needs. Findings include:			incontinent briefs, IDT team	pends	
				HRC approval to utilize deper		
				per the agreed upon plan to depends.	utilize	
	On 9/19/11 from 4:25pm until 5:20pm,					
	and on 9/20/11 from 8:30am until 9:35am,					
	client A was observed at the group home					
	and wore adult incontinent briefs. On					
	9/20/11 at 9:10am, DCS #2 stated client A					
	"wore briefs 24/7 (twenty-four hours a					
	day, seven days a week)" because client A					
	was incontinent.					
	Client A's record	was reviewed on 9/19/11				
	at 4:40pm. Client A's 12/21/10 ISP					
	(Individual Support Plan) did not indicate					
	an identified behavior of incontinence.					
	Client A's 12/21/10 ISP indicated a					
	toileting goal to close the bathroom door.					
	Client A's record did not indicate the use					
	of incontinence a	dult briefs.				
	On 9/21/11 at 9:45am, an interview with					
	the PD/QMRP (Program					
	Director/Qualified Mental Retardation					
		s completed. The				
	l '	ated client A's toileting				
	,	close the bathroom door.				
	l -	ndicated closing the				
	bathroom door d	id not teach client A to				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		15G319		ILDING	00	— 09/21/2011			
		100010	B. WIN		DDDEGG CITY OTHER TIP CODE	03/21/2	011		
NAME OF F	PROVIDER OR SUPPLIER	L.		1	ADDRESS, CITY, STATE, ZIP CODE BRD STREET				
REM-INDIANA INC				PERU, IN46970					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			IAG	DEFICIENCY)		DATE		
	use the toilet. The PD/QMRP indicated								
	client A had an identified need to teach								
	her to use the bathroom and no objective was available for review.								
	was available for	review.							
	This federal tag relates to complaint								
		relates to complaint							
	#IN00096220.								
	9-3-4(a)								
	y-3-4(α)								